EXPLORING THE CIRCLE

A Journey Into Native Children's Mental Health

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This journey is about Native children's mental health. It is an exploration of the Sacred Circle and the essence of Native tradition as it relates to Native children who struggle with their experiences. It is an invitation, on behalf of Native children, to those parents, professionals, planners and administrators who wish to explore and examine the energy inherent within the Sacred Circle.

M.J.A.

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Alberta Children's Mental Health Project
Department of Social Services & Community Health

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The young and the old are closest to life.
They love every minute dearly.

— Chief Dan George

ACKNOWLEDGEMENTS

This document reflects the work of the Core Team of the Alberta Children's Mental Health Project of the Department of Social Services & Community Health. The purpose of that Core Team was to consider children's mental health issues and offer recommendations for the development of a children's mental health service in the Province of Alberta.

During this process, attention was paid to the specific area of Native children's mental health. The Core Team members believed that the issues for Native children were such that a separate document was required that would be distinct from but in context with, the broader document entitled *Expanding The Circle: A Community Approach To Children's Mental Health.*

The members of the team who contributed so much were: Joan Martin, Dean Melsness, Brian Parker, Francie Rauch and Roberta McKeen. Special acknowledgement goes to Gerry Fewster, manager of the project, whose spark kept the energy flowing. Connie Morris deserves a special mention for her good humour despite the many drafts she had to type. Sincere appreciation goes to Winston Wuttunee and family for sharing their life through pictures.

Finally, if ownership exists, then the true owners of the document are those Native people and communities who have shared their quiet and powerful energy with those who wish to explore the Circle. To those people, goes a special thanks.

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PREFACE

In the fall of 1985, a Core Team was established by the Alberta Children's Mental Health Project of the Department of Social Services and Community Health. Resulting from the work of that Core Team, a document entitled *Expanding The Circle: A Community Approach to Children's Mental Health* was published in August, 1986.

The document is an attempt to outline issues and make suggestions regarding the development and implementation of a Children's Mental Health System. Certain standards are suggested that may be used as a framework for the development of a mental health service for the children of Alberta. These standards are:

1. Every young person should have caregivers who understand her/his unique emotional and psychological needs for security, esteem, competency and autonomy.
2. Every young person should have social and emotional support in the exploration and development of the self.
3. Every young person should learn and appreciate societal rules and cultural values.
4. Every young person should be protected from individuals and circumstances damaging to her/his psychological or emotional well-being.
5. Every young person should have support and assistance from caring and knowledgeable adults at times of psychological or emotional stress.
6. Every young person should assume personal responsibility for personal actions.
7. Every young person should be able to modify her/his own behaviour to meet changing circumstances and conditions.
8. Every young person should understand and respect the needs and wishes of others.
9. Every young person should be able to communicate her/his needs to others.
10. Every young person should be able to pursue her/his own potential and sense of personal destiny.

It is our contention that these standards, along with the general thrust of the document are applicable to all children of Alberta — including Native children.

However, it is also our belief that Native Children of Alberta are unique and distinct from the majority population. There are certain forces, experiences, and circumstances that affect Native children which necessitate the development of a separate "mental health initiative" by and for them.

This document is an attempt to outline and demonstrate the uniqueness of Native children and the need for a specialized Native Children's Mental Health Service. It is not our intention, however, to imply that this document is a "final answer" to Native children's "mental health problems". On the contrary, this is the beginning exploration that offers guidelines for an indepth look at the mental health issues for Native children and families. The directions taken within this document rely upon the Core Team's wealth of experience, time spent with various Native individuals, groups and associations and some literature reviews.

The motivation for the document is also based upon our belief that within Native children and families lies the resource necessary to help overcome the many negative aspects of Native communities.

It is our belief that the mental health of Native children, families and their communities depends upon the ability of Native and non-Native people to work together towards a "mental health service" that truly meets the needs of Native children rather than one reflective of a dominant society's view of what is needed.

Our continuing struggle has been to deal with the

issue of how a Native self determined service may be developed. It is our hope that through the concerted efforts of Native and non-Native people, a self-determined mental health service for Native children will develop. It is our belief that what begins as Native input and involvement will develop and evolve into self-determined service.

In summation, this document represents the continuing attempts at cultural understanding and the struggle involved in this process. It is our sincere hope that the readers of this document will join with us in a cooperative process of cultural understanding with the desire to learn from each other.

It will serve the reader well to consider the words of Elder Louis Crier,

> *"Discover and define the harmonies between the two general cultures, between the basic values of the Indian way and those of western civilization — and thereby forge a new and stronger sense of identity."*
>
> (Couture, 1985, p.3.)

PART I
NATIVE CHILDREN'S MENTAL HEALTH SERVICES

Already signs of new life are arising among my people after our sad winter has passed.

— Chief Dan George

INTRODUCTION

We have previously suggested that Native people should be included and involved from the beginning development of a service for their children. To some extent, this has happened in that various Native individuals and groups have been consulted. However, no continuous or regular Native input has occurred. Therefore, a word of caution is appropriate.

Historically, any human services to Native people have been imposed by the dominant society with little attention being paid to the needs of Native people as defined by them. There is a danger that history could be repeated while developing a Native children's mental health service.

We wish to accentuate that the concepts, ideas, issues and suggestions presented here are "theoretical" and based upon little input from Native people. Therefore, as Native participation increases and the service develops, it is likely that this document will be challenged and the end result may be very different from what is presented here.

We have chosen to follow the same format as in our previous document *Expanding The Circle: A Community Approach to Children's Mental Health,* to emphasize the relationship between the two documents.

As stated in that document, we are operating on the principle that "nothing is written in stone" (Fewster, 1986, p. 68). This is truly a consultation document and is intended to generate discussion. It represents the continuing struggle to expand and explore the Circle.

1. DEFINING THE ARENA

In accordance with our document, *Expanding The Circle: A Community Approach To Children's Mental Health*, we believe that concentration must be upon the mental health of Native children rather than mental ill-health. We also believe that this process necessitates an examination of the Native communities in which Native children find themselves.

This examination often results in an extremely negative view of Native communities and many historical responses by human services have been impetuous, quick and inappropriate. We propose that the negative aspects of Native communities often become the overriding motivation for solutions with little attention being paid to the positive elements of these communities and other forces that affect the mental health of Native children.

As a starting point, we wish to present a demographic analysis of the Native population and their communities in Canada and Alberta, although we recognize this information is well documented elsewhere. (Burrows and Hornick, 1986; Department of Indian and Northern Affairs, 1982; DeWaal, 1982; Nechi Institute, 1985; Siggner, 1982).

A cautionary note must always accompany any Native demographic information. Such information is always plagued by inaccuracy because the only "real" statistics available are for the registered Indian population and do not include non-status Indians nor the Metis population. We make the tenuous assumption that statistics regarding registered Indians are reflective of the general Native population.

A further point of clarification is appropriate here. We are aware of the various legal and biological statuses assigned to people of aboriginal ancestry. We refer the reader to various sources for further reading in the area. (Dosman, 1972; Frideres, 1974; Hawthorne, 1966-67; Johnston, 1983).

In the name of simplicity we have chosen to refer to all people of aboriginal ancestry as "Native" and this is in no way intended to ignore or reduce the importance of the various status groups.

For the purposes of clarification, the most significant information is presented in point form:

1. The Native population in Canada is increasing at a rate faster than the general population.
2. The Indian population is younger than the general Canadian population. (In 1981, 51% of the Indian population was under 19 years of age compared to 32% of the general population).
3. Life expectancy within the Indian population increased 5½ years between 1971 and 1981. However, life expectancy within the general Canadian population surpassed the Indian population by 10 years. That is, Indians die younger.
4. The overall death rate for the Indian population is 2-4 times higher than the general population of Canada between birth and 19 years of age. In Alberta, childhood death among the Indian population is approximately 1½ times higher than the average Indian rate in Canada.
5. Estimates are that death by accident, poisoning and violence are, at least, 3-4 times higher for the Indian population than for the Canadian general population.
6. Conservative estimates indicate that 50-60% of all Indian illness and deaths are alcohol related.
7. Indian alcoholism rates are conservatively estimated to be, at least 5 times as high as for the general population. Many Native resources suggest that every Native person has been affected by alcohol abuse at one time or another.
8. The Alberta Native youth suicide rate is over 5 times higher than the general youth suicide rate in Alberta.
9. Unemployment rates are estimated to be anywhere between 50-75% depending upon the particular Indian community.
10. In 1974, it was estimated that 55-70% of the total Indian population in Canada was receiving income security of some kind. This compared to 6% of the general population. Current estimates are that at least 75% of all Native people are receiving income security.
11. In Alberta, about 2-4% of the population is Native, but 20-25% of prison inmates are

Native.

12. School statistics indicate that 18% of the Indian population in Canada complete Grade 12 compared to 75% of the general population.
13. Indian juvenile delinquency is 3 times higher than the general rate in Canada.
14. Although estimates vary, it is generally accepted that child welfare statistics indicate an over-representation of Native children who have contact with the child welfare system in Alberta. Native children come into care 7 times more often and are apprehended 5 times as often as the general population. The end result being approximately 40% of children in care of child welfare authorities are of Native origin.

Statistics for Alberta Native people indicate that they are either average or above average in terms of the above indicators of mental ill-health compared to the Canadian figures for the same population. That is, when compared to the rest of the Canadian provinces, Alberta Native population statistics indicate a level of "dysfunction" that is at least, equal and probably higher than many other provinces in Canada. (Government of Canada, 1980).

There are many factors and forces that come to bear upon Alberta's Native population. Some of these forces play a dual role as contributors to the level of mental ill-health but most shine forth as a hope for the future. We now turn our attention to these forces.

Again, for "clarification", the factors are outlined in point form:

1. **Historical Factors:** It is impossible to appreciate an individual situation without considering that person's history. This is also true for groups and total populations. This is especially true for the Native child, her/his family and community. The unique historical experience of Native people is plagued with attempts at domination, manipulation, and assimilation by the dominant society.

In the 1400s the first encounter occurred between North American aboriginal people and non-Native explorers. By the 1500s, European authorities believed that settlement of North America was essential and the question became, "what is to be done with the aboriginal people?" It was decided in the 1530s that, in fact, aboriginal people were human and therefore, had "rights" to the land. This necessitated the development of schemes whereby the land could be obtained and "bought" from the Native people predicated upon the deep and traditional European value of land ownership.

Thus began a process of takeovers that spelled the end to the existence of the Native people as it was at that time. The more acceptable means of takeover was through the signing of treaties with various groups of Native people. Essentially these were "land deals" and through them groups of Native people became Treaty Indians with certain rights including the formation of the Indian Reserve system.

Less acceptable means of intrusion were often dictated by economics. Examples of these means were the introduction of tobacco and alcohol. In order to ensure that Native people would continue to support the fur trade, a dependence upon alcohol was encouraged.

Other ways of dominating and manipulating Native people were through declaring many Indian ceremonies illegal, introduction of smallpox infected blankets, killing off of buffalo, etc. As the years passed, less obviously intrusive attempts at assimilation have been attempted such as location tickets, encouragement to enfranchise, boarding schools, suppression of Native belief systems and language, etc.

Whatever the means, it cannot be denied that Native existence was seriously disrupted, at the very least, with resulting ramifications that are seen in present day Native populations. For many Native people, this has resulted in lack of parenting skills because of boarding school attendance and being denied the opportunity of learning how to parent. A generalized poor self-image resulted and many Native children today attempt to deny their "Indianness". Native children undeniably feel the affects of the historical basis for alcohol abuse, economic dependence and cultural interference.

2. **Cultural Factors:** Prior to non-Native contact, Native people had a well-developed functional and sophisticated culture. It was obviously related to a generally nomadic existence and in direct harmony with the environment. As with any culture, even thought patterns developed that were appropriate to the "way of life". Therefore, Native people had become circular thinking, in tune with the seasons, spriritually connected to their environment, and very aware that existence depended upon a careful harvesting of Mother Earth's resources.

   A community system had developed which maintained individuals and supported families through maintaining the needs of the group. Boundaries were established in which individual exploration and discovery occurred and the holistic development of individuals was encouraged. Children were seen as the hope for the future.

   Upon contact with non-Native people, an erosion of the culture began including the removal of children and therefore a dimming of visions of the future. Group cohesiveness began to disintegrate. Through intrusive measures, boundaries disappeared that previously had ensured individual and group protection.

   Eventually, it was believed by the dominant society that Native culture would die. In fact, many authorities currently believe that there is no Native culture. However, despite the assaults upon it, Native culture has survived and, if anything, is resurging at the present time.

   This cultural revival is sometimes overt in the form of cultural expressions such as powwows, dancing, Sweat Lodge ceremonies, Sundances, etc. But perhaps more significantly, there is a deep-seated, quiet and powerful revitalization of and return to a spiritual tradition based upon collective thought and community vision (e.g. Alkali Lake experience). In short, there are attempts to re-establish community boundaries and restraints against which responsible behaviour can be measured.

   Often this "return to tradition" has been the motivating force behind increased vocalization by Native individuals and groups. Increasingly, Native people are pointing out that their culture offers many solutions for, not only, their own situation but perhaps could offer enlightenment to the dominant culture.

   This resurgence of tradition offers much hope for children as a positive alternative to an otherwise negative lifestyle. Increasingly, Native children and adolescents are becoming involved in cultural ceremonies and are responding positively through elder contact and guidance. (e.g. Sacred Circle; White Braid Society).

   For those young people already caught in the trap of present child oriented services, referral to traditional Native resources is increasingly an alternative being used by sensitive and creative service providers.

3. **Value Differences:** Obviously connected to culture but worthy of a separate discussion are the value differences between Native and non-

Native society.

It is not only difficult, but perhaps inappropriate for us, as members of the dominant society, to presume we know what Native values are. Rather, we present our general perceptions of what results from value differences and leave further clarification to Native people as they become more our teachers and we the students.

From our observations and experience, Native values result in perceptions and behaviour such as consensus decision, changing leadership depending upon situations, different disciplinary techniques for children, different perceptions of time, religious expression, extended family views, and mannerisms that imply something different in the dominant society (e.g., silence, lack of eye contact, less exuberant hand shaking, lowering the head, etc.). At the same time, Native people are bombarded with and participate in the dominant society with an often conflicting value orientation. This results in the Native child often being caught between two worlds and may result in a terrifying inner conflict.

4. **Tribal and/or Regional Differences:** There is much discussion as to whether a universality exists amongst Native people and whether general statements may be made about all Native people. One side of the debate maintains that it is not only possible, but useful to generalize Native people. Certainly, the tendency of dominant society authorities is to assume Native people "are all the same". The other side of the debate insists that linguistic, Band and regional variations have dictated the emergence of many "little cultures". Therefore, each group or Band of Native people must be viewed differently and have unique needs.

   We believe there are elements of reality within both sides of the debate. There is little question that some basic "truths" exist within Native society throughout North America. Examples of these generalizations are concepts such as the Circle, the number four, Elders, harmony with the environment and the idea of individual power. It can also be demonstrated that socio-economic conditions of Native communities (certainly in Alberta) are generally universal with few exceptions. At the same time, even a superficial glance at Native communities in Alberta indicates significant differences such as specific cultural expressions, organizational structure, administrative sophistication, willingness and/or ability to seek autonomy, etc. These differences are also apparent when one moves from southern to northern Alberta.

5. **Status Differences:** It is well documented in other places (Frideres, 1974; Hawthorne, 1966-67) that several statuses have been "assigned" to Native people by the dominant society. This status assignment is deeply rooted in history and has considerable impact upon the present day situation. Not only do the different statuses become confusing, but individuals and groups of Native people have certain rights and privileges that others do not. These differences sometimes result in individual, family and community difficulties. They also present service delivery problems related to jurisdictional issues.

6. **Native Organizations:** Many Native service and political organizations have developed in this province. Some of these organizations claim specific mandates (e.g., Metis Association of Alberta; Indian Association of Alberta; Native Outreach; etc.) while other mandates are more "fluid" (e.g., Native Counselling Services of Alberta; Native Women of Alberta; Metis Children's Service Society; Nechi Institute, etc.).

Several observations may be made regarding these organizations. First, there is not always a clear distinction between service and political organizations and in some cases, there are indications that political organizations are beginning or will begin exploring direct service to Native people.

A second observation relates to a degree of rivalry among the various groups. There is, at least some indication that "differing opinions" exist among organizations in terms of mandates, service recipients, quality of service and, in some cases, how representative of Native people a particular organization might be.

A third and final observation is a reminder that virtually all Native organizations are, to some extent, dependent upon the Government of Alberta for resources. Therefore, it is difficult for these organizations to be truly autonomous and make absolutely independent statements or recommendations. True self determination is difficult to understand and achieve.

7. **Urbanization:** A separate and very current phenomenon affecting Native people is an increasing urban migration. We believe the process of urbanization is part of a generalized transition of many Native individuals and families. That is, considerable numbers of Native people are in states of transition from a traditional lifestyle to a contemporary way of life. Perhaps this is most clearly seen in the flow of Native people to and from the major cities in Alberta. Urban centres may be the "largest reserves" in Alberta and the rest of Canada.

   There is little question that an increasing number of Native people are perceiving the city to be an alternative to their present situation. There is also little question that the process of urbanization has many facets (e.g., motivation for migration, migrants, perceptions of the urban environment, preparation of prospective migrants, service delivery within the urban setting, etc.).

   As usual, Native urban populations do not form an homogeneous group. Rather, there are many linguistic, tribal and status differences. Some are more contemporary and "sophisticated" than others and the list goes on. We believe there are many difficulties that Native people face in the urban setting. These may result in "mental health issues". In fact, the very process of urbanization often becomes a mental health issue for Native children and their families.

8. **Biological Issues:** The possibility that biological differences exist between races has long been avoided. A recognition of potential or real differences has been perceived to be an adherence to notions such as superior/inferior; better/worse; strong/weak; dominance/submission.

   However recent suggestions made by some Native individuals and Native sponsored programs indicate some basic differences may be present between Native and non-Native people. Our purpose in raising this issue is to reinforce the notion that the ramifications of cross-cultural exploration are indeed broad and varied.

It is our intention in presenting these factors and outlining the demographic data, to point out the various forces that affect Native children, families and communities. Our purpose is to emphasize that the uniqueness of the "Native situation" is so profound that it is very dangerous to make assumptions and generalizations. It is equally disastrous, but tempting, to make conclusions regarding Native children and services to them, without an appreciation of the dynamic world in which they find themselves embroiled.

It is our conclusion that the arena of Native

children's mental health is many faceted, complicated, little understood and plagued with the notion that "we know best".

As with all children's mental health, we must step back and begin a learning process for ourselves prior to offering solutions to our perceived definition of the "problem".

In short, we believe Native children and families to be our teachers and we, the students, have much to learn, appreciate and understand. It is the Native children and families of this Province who should and will tell us the direction that any children's mental health service should go.

Having said this however, we also recognize that a starting point is necessary in order to begin consultation with and learning from Native people. The remainder of this document is our attempt to raise the issues of need identification, strategies, resource acquisition, organizing and mobilizing resources, establishing linkages and evaluation models.

Young people are the pioneers of new ways.

— Chief Dan George

2. THE IDENTIFICATION OF NEEDS

Need identification is indeed difficult and perhaps represents the most significant stumbling block to the development and implementation of any human service. It is our contention that many human services have developed to meet the needs of service providers rather than client or recipient needs. This may be especially true for services to children as we adults usually assume that we not only know what is best for children, but that we act in the child's best interest.

This assumption is even more often made when the client population is Native. For many reasons (history, prejudice, racism, guilt, shame, etc.), Native people are often viewed by those of us in the dominant culture as being "child like" and therefore unable and/or incapable of designing their own existence. They obviously require the help of those "who know best".

And so, the issue of need identification within the Native child population becomes a double-edged sword — they are both Native and children.

The issues surrounding need identification that were outlined in *Expanding The Circle: A Community Approach To Children's Mental Health*, certainly apply to Native children's mental health. However, there are additional issues to consider.

1. Native leadership does not necessarily represent all Native children. That is, just as the dominant culture's elected and/or appointed leaders do not always speak to the "real" needs of the general population, so is the case with Native leadership.
2. The present non-Native service providers, although well intentioned, are incapable of truly perceiving the needs of Native children realistically. The day-to-day existence of the Native child and her/his family is so removed from that of the service provider, we suggest that need identification by service providers should be considered but certainly is not the "final answer". Native service providers are better able to offer enlightenment in that personal childhood experiences increase their sensitivity to the general needs of Native children.
3. The issue of need identification becomes further complex when the factors outlined earlier in this document are considered. For example, tribal and/or regional differences will very much affect the identification of needs. That is, the needs of the urban Native child will be different from those of a Native child who is resident of a remote Northern community. The needs of a child who is a member of the Blackfoot Band will be different than a child who is a resident of the Sunchild Reserve.
4. Cultural and value differences are central to the identification of needs issue. The question becomes whether "mental illness indicators" that are usually used to determine need within the dominant culture mean the same thing within Native culture. It is our belief that some of the usual indicators of mental illness (e.g., hallucinations, delusions, compulsive behavior, depression, etc.) may have a different meaning within Native culture and may, in fact, not represent the same "need" at all.

Having outlined some of the difficulties with need identification for Native children and families, we are also prepared to offer suggestions as to how a more realistic needs assessment might be accomplished.

1. **Be prepared to move slowly.**
   Any attempt at needs assessment must be in accordance with the cultural norms of Native communities. This necessitates a careful, deliberate and accurate picture being drawn of the need. Relationships must be developed with Native individuals, groups and communities so a level of honesty exists that allows for a true needs assessment.
2. **Assess present service to Native clients by current Government mental health services.**

Develop a clear picture of what services are currently being utilized by Native children and families to begin the process of understanding what the current picture really is. This assessment must be done regionally and include demographic data, diagnosis, length of contacts, Native status, number of contacts and therapeutic outcomes.

3. **Assess present service providers' perception of the needs of Native children and families.**
This assessment must include their perception of mental health difficulties, increased resources required to meet the needs, service provider needs in relation to delivering service to Native children and families, and service delivery modes.

4. **Community-based needs assessment.**
This is the most difficult and complex area of need identification for Native children and families because it must allow for the various factors that are unique to Native individuals, families and communities. To help clarify the complexity, this assessment must occur at different levels.

   a. **Native service providers.**
   The various Native individuals and groups that offer current services to Native people must have input into the identification of the needs. We emphasize the requirement that this segment of the needs assessment must be broadly defined and include service providers from fields such as education, child welfare, corrections, recreation, housing, employment readiness programs, family life education, and cultural groups.

   b. **Consumers and potential consumers.**
   We believe this component of the needs identification process to be the most significant but also the most difficult to accomplish. Issues such as access, methodology, trust levels, accuracy, etc., become apparent. Despite these obstacles, we believe that children and families are best able to identify their own needs and provide for planners the most accurate picture of what is needed.

   There are no concrete answers as to how this needs assessment may be accomplished but several suggestions have been offered by Native people through our brief contact with them. They have stated clearly that children and their families must be interviewed in a culturally sensitive way, and asked directly for their perceptions of current service provision, their suggestions for changes in service delivery, and their observations of the gaps and deficits in service.

Having made these observations of the identification of needs issue, we are now prepared to offer suggestions as to how needs may be identified.

1. **Development of a team of individuals, Native and non-Native, that would develop, plan and implement the needs assessment process.**
This team would be comprised of regional representatives from the community at large but would be employed by the Department of Community and Occupational Health. The team would be coordinated by the Coordinator of Native Children's Mental Health. They would not necessarily be connected to current provision of services in any way.

2. **Development of appropriate methodology and tools for assessment of need.**
This process, actualized by the team, would necessitate the involvement and consultation with "classical" researchers, (including those oriented toward participatory research), community people, and Native advisors in an attempt to gather accurate, sensitive, reliable, and culturally appropriate data and information.

We emphasize the absolutely essential consumer component and believe that this portion of the needs identification requires unique and creative energy using such techniques as individual and group interviews, interpreters and gatherings of the People.

3. **Incorporation of culturally appropriate resources.**
   It is of utmost importance to include a consultation process between the team and Native people that would ensure a continued sensitivity to value and cultural issues. Part of this process would be the inclusion of Elders' input to the team on a regular basis.

We believe, as do the Native service providers already contacted, that any need identification process, must be community-based, holistic, and very culturally attuned. To accomplish this, the process must move slowly and be of high quality. To move too fast would result in reliance upon assumptions with inappropriate and damaging services being developed.

Historical analysis indicates that good intentions do not always have positive results. For the sake of Native children and families, it is encumbent upon those completing the need identification process, to ensure that history does not repeat itself.

3. STRATEGIES

Another word of caution is appropriate here. We have attempted, so far, to emphasize that it is of utmost importance to include Native people in the planning and development of a Native Children's Mental Health Service. To date, this input has been minimal and therefore, it is essential that our suggestions within this section be viewed as very tentative and likely to change as Native participation increases.

A second word of caution relates to our belief that deep cross-cultural issues exist whenever people of different races come together in an attempt to communicate. These issues become extremely significant when the "client population", of any human service, is from a minority group.

Historically and certainly for some time to come, the major decision-makers, planners, developers and service providers of mental health have been and will be members of the dominant society. The present system reflects the dominant values of that society. Prior to making our suggestions in terms of strategies for a Native Children's Mental Health Service, it is useful to reflect upon the cross-cultural issues that directly affect service provision.

Perhaps in no other area of service provision does the issue of value conflict become so important as in the "therapeutic relationship" between a "helper" and "client", when they are from differing racial groups. Over the years, the literature has offered various points of view. Some authors have suggested that it is impossible for service providers and recipients to relate positively when they are from differing racial groups (Kennedy, 1952). This is primarily attributed to the inability of the "helping professions" to shed their "cultural baggage".

The opposite extreme is also seen in the literature where the suggestion is made that racial differences between service providers and clients are irrelevant to the relationship (Schacter & Batts, 1968; Silverman, 1971). These authors suggest that the professional values of the service provider are such that they override any cultural values that may hinder service provision.

We choose to "walk the middle road" and suggest that certain differences exist between cultural and racial groups and that it is absolutely essential that service planners and providers be aware that differences exist and how they affect any cross-cultural interaction. In other words, we believe it is mandatory that service planners and providers achieve a certain level of personal awareness, in terms of value and other differences, in order to ensure the constructive and positive development of a service. We do not believe that adherence to professional values alone will remove cross-cultural difficulties. The issue is more personal than that. Without this level of awareness a service may develop which is based upon service planner and provider needs. Also the actual interaction within the therapeutic setting may be plagued by value conflict or, worse still, value imposition by the "helper".

It is useful, here, to briefly examine some specific cross-cultural dynamics that serve as a cautionary reminder that members of the helping profession are not necessarily free from their own value system and may impose certain perceptions and expectations on clients from a differing racial group. In this specific case — Native children and families.

Racism pervades society and "we are all heirs to the legacy of racism" (Cooper, 1973, p. 127). The reminder here is simply that virtually all social service personnel are members of the dominant society and, with this orientation, has come a heritage that is difficult to shed. Therefore, a social distance develops between "helpers and helpees" that is hard to bridge. In this sense, the "specific helping encounter represents a microcosm of societal conditions" (Gitterman & Schaeffer, 1973, p. 154).

Another cross-cultural dynamic relates to the "guilt complex" (Miller, 1973) that plagues many

members of the helping professions. This feeling results from their perceptions of how a particular racial group has been treated by the dominant culture. This may be especially significant to how Native children and families are perceived. The results of this "guilt complex" are often seen in service providers behaving in a paternalistic fashion towards clients. Service providers may over-emphasize the cultural differences and perceive clients from a different racial group as "cultural carriers and not as people". Planning and service provision often becomes "plagued by unrealistic rescue fantasies and activities" (Cooper, 1973, p. 128).

In addition, the helping professional may adhere to what has been called "cripple psychology":

> *"In an effort to relate compassionately to the very real oppression of minorites, many therapists lose clinical objectivity. They view all minority patients as victims, unwittingly reinforcing personal pathology."*
>
> (Cooper, 1972, p. 139)

A final dynamic that both affects and is affected by cross-cultural interaction is the equality of service principle. For many different reasons, it has traditionally been argued that the equality of service and equal access principles are of absolute importance. We agree that these principles are of utmost importance; however, we also suggest that they have been used to "prove" that any particular service is not racist. Some authors have argued that, in fact, the emphasis upon equality of service and equal access has been "inappropriate at best" because it does not address the reality of differing needs (Wells, 1982), and racist at worst (Miller, 1973).

We believe that the equal access principle must be applied to any service but that the equality of service principle may result in different kinds and forms of service to different individuals and groups.

Before leaving the strategy issues, it is important to remember that not only does the "helper" bring personal and professional values, biases, beliefs and perceptions to the cross-cultural interactions, the "client group" (in this case Native people) also carry with them many biases and perceptions that may hinder interaction.

Long term personal and cultural subjugation may result in an inherent anger that contributes to a denial of the problem or a reluctance to seek or accept help. An absence of boundaries or guidelines for behaviour contributes to a lack of definition of responsible behaviour. The current political climate may encourage a tendency to "blame the white system" for certain behaviours and dull awareness of individual difficulties. Cultural dynamics emphasize the need for individuals experiencing difficulties to approach helpers in particular ways and with certain expectations that are not compatible with present mental health or social services systems.

In short, Native/non-Native interaction is a two way street and it is important to concentrate upon the positive aspects of the interaction rather than placing blame on either side.

Having made these observations, it is with some fear and trepidation that we plunge forward to the task of examining possible strategies for a mental health service to Native children.

In our attempts to "take a fresh look" at mental health services to Native children, we are forced to admit that many more questions exist than do answers. We also readily admit that a reliance upon the present system is inappropriate. It is therefore necessary that we consider broad issues of strategy. We expect these issues to elicit much debate.

To this point, Native people have indicated the following in terms of a strategy for a Native Children's Mental Health Service.

1. **The service must be community-based.**
It is essential that whatever strategy is useful in meeting the identified needs, it must be based within the child's community, wherever that might be. This increases accessibility to the service, the service becomes less threatening and, therefore, the use of the service would increase.

The actual location of a service may be within the school, church, Band office, a private home or any other community building. Or the service may be mobile and travel to the child and her/his family. The emphasis here is that each community is unique and, therefore, any service developed must express and exemplify that uniqueness.

Obviously, the strategies developed for each communtiy are dependent upon the identified need, but we believe some general guidelines are appropriate and essential to the development of appropriate community-based strategies:

a. Knowledge of and communication with the community "political" structure.

b. Knowledge of formal and informal leadership and decision-making.

c. Understanding of the decision making structure in each community.

d. Awareness of the community's present resources (*e.g.* social services, recreation, education, health services, etc.).

e. Knowledge of each community's demographic variables.

f. Understanding and appreciation of each community's historical tradition (*e.g.* cultural, non-Native contact, boarding schools, Treaties, etc.).

g. Knowledge of socio-economic variables (*e.g.* employment, housing, etc.).

h. Direct involvement of community members in the planning and implementation of any service.

2. **The service must be educationally-based.**
This principle is multi-faceted and must be broken down to emphasize the various components. We do this only for clarification and do not intend to imply that each is a separate entity.

a. **Education of parents and caregivers.**
We contend that within our society, confusion abounds in relation to the developmental needs of children. In fact, there seems to be a general lack of knowledge, and understanding of the social, psychological and emotional well-being of children.

This lack is also seen, and perhaps accentuated, among many Native parents and caregivers. For various reasons that we outlined earlier, many Native parents and caregivers are often so embroiled, as are all parents, in their own difficulties that the needs of their children become less important and, in some situations, completely ignored. When this has happened previously, child welfare authorities have become involved and the removal of children from their families has often been the result.

We suggest that a major component of a mental health system for Native children is the education of parents and caregivers as to the needs of their children. It is our view that often more intrusive interventions could be replaced by an educational model that would emphasize the mental health and "normality" of children and encourage parents and caregivers to address the needs of their children.

This would require a change of emphasis among the professional providers of mental health services. The knowledge of these pro-

viders would have to be shared rather than guarded as the domain of the experts. In many instances, the dissemination of information and the teaching of skills relevant to the needs of the recipient (our definition of education) would be reciprocal between the "client" and the professional. Our view is that professionals also have the "need" to understand the "world from the client's eyes" and develop culturally appropriate knowledge based upon client-professional interaction. This process would be facilitated by specific training experiences for present service providers. It is our view that without specific training, present service providers are generally unable to do this.

b. **Education of children and adolescents.**
It is important to remember that Native children and adolescents have additional developmental and identity issues when compared to children and adolescents who are members of the dominant society. That is, the "normal" identity issues that children must face are accentuated when that child is Native. Native children are faced with threefold identity issues.

First, they must process what it means to be a child and this incorporates the usual issues associated with this developmental process — individual identity, sibling relationships, peer relationships, parent-child issues, etc.

Second, the Native child must confront the issues associated with being a Native person — learning value orientation, proper behaviour, cultural orientation, family relationship, etc.

Third, the Native child must learn about non-Native society and determine where she/he "fits" with that. This includes such issues as dealing with prejudice, examination of dominant values, cultural orientation, etc.

In our view, the Native child is often "caught" between two worlds and the result can be turmoil, anxiety and personal difficulties. In other words, the Native child is often in a state described by social scientists in a variety of ways — "value conflict"; "culture shock"; "anomie"; etc.

Often what is a "normal" developmental process for the Native child becomes an issue for child welfare authorities or is described by mental health professionals as some form of "mental illness".

We believe the issues confronting Native children and adolescents to be developmental ones and that these issues are simply accentuated because the child is Native.

The educational component of a Native Children's Mental Health System would view the child as going through developmental phases and educational programs could be developed that would address the issues Native children face and facilitate their developmental process. Examples of such programs would be cultural awareness related to both cultures; positive adaptive behaviour when confronted with prejudice; agency information; alcohol education; parent-child relationships; etc. In other words, provide experiences for children in which they discover the richness of living in two cultures.

We are not suggesting that all traditional mental health services should disappear nor are we suggesting that the educational services should be exclusively the mandate of a mental health service to Native children. Rather, we believe that the educational endeavour must be shared and that many

Native and non-Native community resources are available that are willing and more able to do the job. Schools, Band councils, health units, hospitals, recreational groups, families, and Elders are all examples of such resources. Perhaps the major responsibility of a Native Children's Mental Health Service would be to provide leadership, coordination, information and enlightened expertise developed from within a holistic philosphy and skilled as a result of training in cross-cultural issues.

c. **Community education and awareness programs.**
Another segment of the educational component is based upon the belief that many Native communities are so "wrapped up" in their own difficulties and problems that they are unable to see the proverbial forest for the trees. Many of these communities could benefit from self-directed educational programs that would encourage them to step back and take a fresh look at their situation with a view to problem solving. Such programs may include alcohol education, suicide education, reduction of stress, management techniques and budget information.

At first glance, such endeavours appear to be unrelated to children's mental health but, from our view, any mental health service must operate from a broad philosophical base and an equally broad mandate. In this sense, the children's mental health system would provide leadership, coordination and support for what could be described as community development with an emphasis upon assisting communities to build a vision of health.

3. **The service must be preventive.**
Closely aligned with the educational component is the area of prevention. In fact, most Native resources have indicated that education and prevention, from their perspective, are so closely entwined so as to make it difficult to distinguish between them.

From the preventive point of view, it is necessary to look beyond present individual and group trauma and concentrate upon residual and potential individual, family and community strengths.

In order to facilitate this point of view, we have supported and still do support the position of the Department of National Health and Welfare who propose prevention to be an attitude rather than a program. In their terms:

> *Prevention is an attitude, questioning and imaginative, and also unencumbered by the constraining of narrower perspectives that too often characterize particular work settings and daily routines.*
>
> (p. 6)

If this position is adopted, we are then freed to consider all alternatives in an attempt to focus upon positive outcomes such as improvement in the quality of children's lives. This, in turn, leads us to consider all aspects of a child's life that may promote and enhance an increased quality of life. A mental health service for Native children may then find itself considering such areas as community economics, recreation, etc. We have become increasingly aware that the mental health of a child is closely related to his environment with a particular strong relationship to his primary relationships. Therefore, we conclude that strong, functional and positive familial relationships can offset mental "ill health".

As usual, the area of prevention in Native

communities and groups becomes more complicated because of the differing cultural context. So, if prevention is to become viable and useful, an understanding of Native culture is essential. If the specific thrust of prevention is towards the Native family, then an increased awareness of Native family structure is necessary.

In *Expanding the Circle: A Community Approach to Children's Mental Health,* we presented our approaches to prevention and outlined our orientation towards primary and secondary prevention (Fewster, 1986, p. 16-22). Suffice it to say that we believe these principles apply to Native communities and that the same creativity and sensitivity must be applied when developing preventive programs within Native communities. A primary example of such a preventive program is at Alkali Lake, B.C.

Again, the primary responsibility of the professionals with a mental health service for Native children would be to coordinate, motivate and encourage community resources towards preventive thinking and support the development of a preventive attitude within Native communities.

Although requiring confirmation by Native people, perhaps two areas that require preventive attention are alcohol use and urbanization. We have stated earlier that many Native resources identify alcohol abuse as the number one difficulty that Native people face. Therefore, it is argued that the major preventive thrust must be towards innovative and creative preventive programs geared to the education of alcohol abuse. Urbanization is seen as a destructive process for many Native children and families. We believe that specific attention must be paid to the development of programs that would enhance and strengthen children and families towards more positive adjustment to urban living. In other words, Native people in transition (perhaps the majority) could benefit from programs that would prepare them for various transitional difficulties (*e.g.* prejudice, discrimination, loneliness, fear, housing, agency access, family issues).

Obviously, the concept of prevention is very diffuse and non-specific but of absolute importance to the development of mental health amongst Native children. The helping professions can no longer hide behind the structure of mental illness concepts. Rather, the call is for a changed attitude regarding the strength of those people seen as service recipients. The call is to begin considering programs that will prevent Native children and families from walking into the diagnostic trap of present mental health services. Experience has shown this trap does not work for the majority population. We wonder why it should work for Native children and families.

Having said this, however, it is also obvious that no matter how "preventive" a mental health service becomes for Native children, it remains a "band aid" service when considered in relation to economic issues. Issues such as poor housing, overcrowding, lack of employment confront Native communities daily and cannot be ignored. Until these issues are dealt with, the impact upon Native children and families is profound and, to some extent, hinders the development of a positive mental health service for Native people.

We do not see the improvement of Native community economic conditions to be the direct responsibility of a mental health system for Native children and families. Rather, it is essential that Government, as a whole, recognize and accept their responsibility in order

that the preventive thrust of Native Children's Mental Health be more than a band aid service.

4. **The service must be holistic.**
Any mental health service for Native children must be holistic both in terms of the individual and his environment. We believe that every child has physical, emotional and spiritual needs. Traditionally these needs have been compartmentalized and distinct professionals claim a certain expertise to deal with each category of needs when the need is not being filled. The physician claims ownership of the knowledge that addresses physical need although too often physicians' expertise is perceived to incorporate the other categories as well. Certainly, child welfare authorities claim jurisdiction here, too.

Emotional needs are usually within the realm of mental health professionals, school authorities and to some extent child welfare authorities.

Spiritual needs are usually ignored with the exception of organized religion whose professionals claim ownership but have rarely been truly effective in addressing the spiritual needs of Native children.

We believe that the dissection of the needs of children has often resulted in fragmented, disorganized, and ineffective service delivery. It is the child and her/his family that has suffered.

From our point of view, a change in perspective is required. Children must be viewed as whole beings that require nurturing of all needs at the same time. One category of needs cannot be separated and considered distinct from another.

We suggest that those of us who have been raised, trained and educated within a Western European tradition must look to other traditions for an orientation that views children as whole beings. One of those orientations lies deep within Native tradition and, from our viewpoint, helping professionals from all disciplines must become attuned to the very tradition into which Native children are born. That is, an holistic view of individuals, families and communities, will only result when helping professionals are prepared to become the learners; the students of the culture and the children which they are trying to help. This process would require that the professional be trained holistically — information assimilation, skill development and attitude development.

Obviously, if the Native child is viewed from a holistic viewpoint, it then becomes necessary for the helping professional to rely upon other resources. In terms of mental health professionals they can no longer be the end all and be all to those she/he is trying to help. At this point, an holistic view of the Native community must be cultivated and developed. It is necessary that community resources be used in order to address the total needs of each Native child. Therefore, increased referrals, consultation and general contact with Native and non-Native resources must occur.

We believe that residual power, energy and creativity exists within the Native community. We also believe that, generally speaking, non-Native professionals are unaware of this. It is not only useful but essential that a mental health service for Native children become aware of that power and energy. Ways of communication and coordination must be learned that will allow for the expression of that power and energy by Native people in a way that will facilitate the mental health of their own children.

We believe that deep within Native tradition lies an holistic view of individuals, families,

community and the world — mind, body and spirit in all things. The development of a positive and creative mental health service for Native children rests upon the willingness and ability of mental health and other professionals to shed their diagnostic cage and allow themselves to communicate, take direction and learn from "those who have been there" — Native children, families, and spiritual leaders.

5. **The service must incorporate significant Native input at all levels.**
   To date, Native input has been minimal and there has been no concerted effort to tap the Native resources that are available and willing to participate. As we have stated previously, it is essential to include Native input at the beginning phases of identifying needs and there must be continuing Native involvement through to and including the implementation and evaluation phases.

   By Native involvement, we mean more than the traditional "token Indian" participation on comittees, planning groups, and the like. We insist that purposeful and unique recruitment to the development process must occur. It is necessary to ensure representation from various regions, status groups, etc. A fair representation of female input must occur. A further essential component is regular Elder input, not only for consultation purposes, but we believe that the spiritual needs of the planners, developers and implementers must also be met.

Within the area of strategies, two remaining issues are significant.

1. **Child Welfare Services.**
   We choose to define the child welfare system in a very broad fashion. We include all mandated systems that intrude upon the Native child's life — recognized child protection services, legal systems, treatment facilities, etc.

It is common knowledge that Native children are overrepresented within all of these systems. It is obvious that major jurisdictional issues exist between the various systems and often these issues affect the service to Native children in a significant way. There has been a traditional "rivalry" and sometimes an all-out war, between mental health professionals and other professionals that are charged with the mandated responsibility for children. Too often, mental health professionals have assumed that child welfare workers, for example, are not qualified to perform mental health duties. At the same time, child welfare workers tend to assume that mental health workers "cannot tell them anything new."

The child often becomes the proverbial "ball" that is bounced back and forth between the professional courts. She/he becomes an object over which ownership is declared.

It is necessary for any mental health system to recognize that child welfare workers are mandated as caregivers of many Native children and, as such, are valuable resources. Theoretically, child welfare workers know their children best and act in the child's best interest. As such, they become an essential part of the assessment, diagnostic and treatment process. This view may also be applied to other jurisdictions.

In order to act in the best interests of the Native child, it is necessary for all jurisdictions to adopt a cooperative and collaborative stance. There is no longer any room for the ownership of expertise or service. Especially when offering service to Native children, no one discipline or jurisdiction can claim any degree of expertise. Rather, all jurisdictions have failed in offering services and so the role of a Native Children's Mental Health Service would become one of leadership, coordination, cooperation and

collaboration in the learning of new ways to ensure that all jurisdictions may respond more positively to the issues faced by Native children and families.

2. **Mental Health Treatment Services**
As stated in *Expanding The Circle: A Community Approach To Children's Mental Health,* we believe that the provision of treatment services is the direct responsibility of a designated children's mental health system. These treatment services must be based upon a thorough assessment and may cover a broad range of psychotherapeutic interventions directed toward individuals or groups (Fewster, 1986, p. 25). Having said this however, we also recognize that traditional mental health services to Native children and families have not been accessed by them and, when they have, the service has often been inappropriate at best, and damaging, at worst.

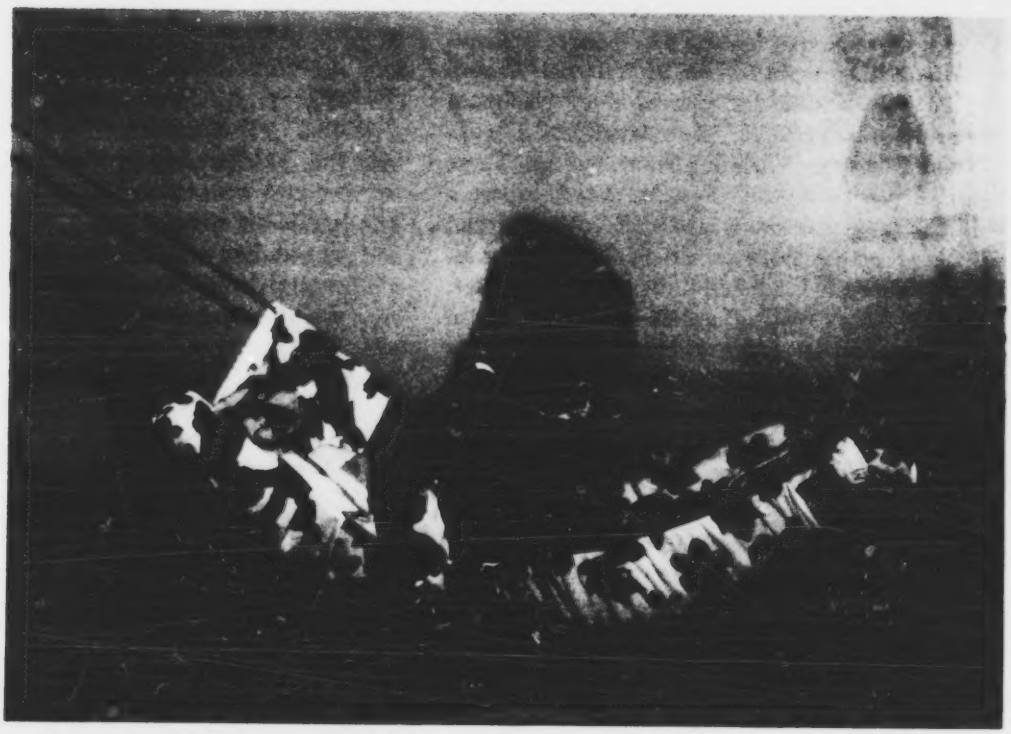
In our view, any mental health treatment process must be based upon identified need and the willingness and capacity of the client to make use of the service. Issues such as access, availability, therapeutic techniques, professional qualifications of staff, racial orientation of staff, and staff training become significant.

We contend that the uniqueness of the Native condition demands a re-examination of the complete mental health treatment philosophy, techniques, interventions, expertise and training. For example, we submit that current assessment techniques are generally questionable and in most cases are certainly not appropriate to Native children and families.

It becomes obvious that current mental health professionals, if they are to begin appropriate treatment for Native people, must not only question their current techniques, but also learn new ways of operating when "treating" Native children and families. When defining the arena of Native children's mental health, we outlined several forces that affect Native children and families. These factors must be considered when treatment services are offered to Native people.

A further observation of treatment services is appropriate. The assumption has been made in other jurisdictions (*e.g.* child welfare services) that it is more appropriate to have Native child welfare workers servicing Native clients. We would like to emphasize that this is an assumption and we suggest it would be dangerous for a mental health system for Native children to make the same assumption. Our contact with Native people, to this point, suggests that it is not necessarily true that Native "clients" prefer or demand service from Native professionals. Rather, the issue is one of service quality and the expertise of the service provider to relate to the whole person. This is not to say we are unsupportive of Native people being hired as mental health providers where possible. But, we contend that it is necessary that these people be qualified (the right kind of people) to offer service. Native people have told us that to be Native is not enough.

The ideal would then be to have professional Native service providers offering traditional mental health treatment when that is appropriate. To accomplish this, present educational systems (Schools of Social Work, Faculties of Psychology, Psychiatry, Nursing, etc.) must accept the challenge of developing culturally sensitive programs that would be available to Native people.



Touch a child — they are my people.

— Chief Dan George

4. ACQUIRING RESOURCES

The allocation of scarce resources to any human service is a perennial difficulty. Often human service programs are not a priority in terms of resources and therefore budget issues become of a significant concern. New programming is often prevented because no new funding is available. We contend that, while some new resources will be necessary to develop a mental health system for Native children, the service should not be "put on hold" because of budget constraints. We offer several suggestions that would facilitate the development of a service to Native children. These suggestions require little budget increase.

The Community as the Primary Resource Pool

We have emphasized previously that there is a traditional lack of use of community resources by mental health services. This is especially true for Native communities. We suggest this is completely false and that, in fact, many resources do exist. A concerted effort must begin to tap the resources that already exist and this effort requires a change in attitude by mental health services people. There must be a shift to the following beliefs:

1. **Clients have residual strengths and resources of their own.**
   Clients, in fact, may form the biggest resource pool available. The mobilization of this recipient resource may take several different forms — ownership of their own difficulties, self-help groups, buddy systems, and "big brother/sister programs" for example.
2. **More community resources exist than are obvious.**
   We have previously suggested that a certain power and energy exists within Native communities but often the non-Native person looks at Native communities through the prejudiced glasses of an outsider. A general return to tradition by Native people has resulted in individuals, groups, programs, and activities that are of absolute importance as potential mental health resources. Examples such as Elders, Sweat Lodges, Sacred Circles, Sun Dances, alcohol treatment programs, and healing ceremonies come to mind.

   Mental health service people have traditionally been inactive in developing community resources. It is now time for those professionals to stop waiting for resources to appear magically before them. A Native Children's Mental Health Service would need to actively search out community resources. These activities may range from "official" resource surveys to individual professionals becoming a part of a community in such a way that she/he simply "knows" and "becomes aware" of the resources.

   To facilitate this process, political and bureaucratic leaders must "grant permission" for more non-traditional behaviour on the individual professional's part. These leaders must spend less time being concerned about quantifying employees' time and encourage the behaviour that would result in resource development. We recognize that this would require a certain skill development level within employees and may require in-service training of present staff. We also acknowledge that it is often the behaviour we are calling for that results in an employee being branded as a troublemaker by the system.

Professional Services

Partly because of the allocative nature of dispensing resources, individual jurisdictions within human service organizations become self-centered, defensive and motivated towards empire building. In short, what began as a human service dedicated to quality recipient service becomes a "camp guarded at all cost". We suggest that a major role of the planners and providers of services to Native children would be to access already existing professional and

other services. This requires the recognition that the provision of mental health services is not the exclusive domain of the mental health professional. We recognize that such endeavors are plagued with difficulties but to become ground to a stand-still waiting for allocation of resources is not acceptable when professional and other resources currently exist that can be relied upon to "do the job" as well.

Non-Traditional Approaches

Perhaps in no other area of service delivery does the demand for non-traditional approaches become so apparent as in service to Native people. We have argued that the uniqueness of Native people demands a different approach to mental health services.

It is recognized that traditional approaches to mental health services are costly and there is some debate as to their effectiveness. Some of the alternatives we have already suggested are somewhat non-traditional. However, further attempts must be made in terms of non-traditional approaches. What we are advocating, in terms of service to Native children and families, is the development of a service that incorporates a broad community development approach. This approach obviously is aligned most closely with the art of social work and it may be more cost efficient to concentrate mental health social work in that direction. This would require in-service training programs as present schools of social work do not provide appropriate education in the area.

Such an approach is community specific and demands that a broad view of mental health be developed with a sensitivity to value differences. The rubric of mental health would include such issues as housing, economic development, recreation, employment, etc. This, in turn, recognizes the need to work collaboratively and cooperatively with other service providers, agencies, community groups, service clubs, etc. This approach suggests that these other resources may either be able to "do the job" for mental health services or sponsor mental health programs. For example, a service club sponsorship of an adolescent hockey team may be as much, if not more, a mental health initiative as the direct provision of psychotherapy to an individual child.

This approach presupposes adoption of the belief and attitude that children's mental health issues are best addressed through a service based upon accurate need identification, sensitive strategizing and community input and responsibility. If planners and administrators adopt this viewpoint, then their emphasis becomes less concentrated upon the attainment of bigger budgets and more directed towards the creative use of existing funds. Other endeavors become recruitment of community resources, redefinition of staff activities, quality of service, etc.

In short, the challenge becomes a joint venture between community and policy makers in order to build a common vision which is both responsible and creative within existing budgets.

5. ORGANIZING AND MOBILIZING RESOURCES

In *Expanding the Circle: A Community Approach To Children's Mental Health*, several suggestions were made regarding the issue. All of these suggestions and observations apply to service to Native children. It is only left to point out two additional difficulties that arise within the Native context.

Establishing a Legal Mandate

We believe that any legislation of children's mental health system must include a section specific to Native children. This would officially recognize and establish the uniqueness of Native people.

The issue of legal mandate to provide a service to Native children is fraught with difficulty and is a jurisdictional nightmare. In short, depending upon individual legal status, Native people are the "responsibility" of particular levels of government.

At the same time, there is no reference to mental health services within the Indian Act and, therefore, one may assume that the responsibility for such services is devolved to the Province of Alberta.

Another issue rests with particular Indian Bands, some of which may feel that Treaty rights are jeopardized if they accept service from the province.

Obviously the legal mandating of Native Children's Mental Health Services is complicated but our commitment to the need for such a mandate is no less because of these complications.

6. FUNDING

Obviously connected to the legal mandate issue, the issue of funding is complicated by the same jurisdictional questions. What level of government is responsible and willing to accept responsibility for Native individuals and groups of Native people? Our experience tells us that many Native services have become seriously hindered because of jurisdictional disputes and it is mandatory that this does not occur within mental health services for Native children. We believe that the importance of the service is such that one level of government should accept responsibility for funding. Because of the lack of obvious federal responsibility, our view is that the Government of Alberta becomes responsible.

In addition to these issues, two cautionary notes are appropriate. First, it would be a mistake to rush head-long into agreements with individual Indian Bands for them to provide their own mental health services. This would be premature and has the potential of a "second class service" being offered.

Second, the fee-for-service issue is especially important when talking about service for Native children. While we recognize that present services do not address the mental health issues which Native children face, it would be inappropriate and, perhaps even dangerous, to make the assumption that those people (Native and non-Native) offering fee-for-service arrangements "know what they are doing." In short, fee-for-service programs must adhere to the same standards as the "regular" mental health system and be monitored closely.

An added safety mechanism would be the right of refusal or the right of approval of any mental health service by particular Indian Bands, Native individuals and groups, etc. In other words, an added assurance of quality control would necessarily be through the request and approval of a service by any Native group receiving service.

7. INFORMATION SYSTEMS AND EVALUATION MODELS

We believe that any information and evaluation systems must be developed in such a way so as to enhance the quality and effectiveness of direct services to clients. It is therefore imperative that such systems be sensitive to Native recipients. We have emphasized the cultural and value differences that demand unique information and evaluation systems.

At this point, we do not know what a mental health system for Native children will look like, but our assumption is that it will be non-traditional, unique and different. Somehow, the information and evaluation systems must enhance that system. The development of these systems is going to demand a creativity and sensitivity to the cross-cultural issues. It will also require a flexibility within the systems designers who will not be able to rely upon "the ususal" to develop them.

PART II

MENTAL HEALTH SERVICES FOR NATIVE CHILDREN, ADOLESCENTS AND THEIR FAMILIES IN THE PROVINCE OF ALBERTA

INTRODUCTION

Throughout North America, Native people are surging forward toward self-determination. Individuals, groups and communities are in a period of self-examination. There is an increasing awareness that what has been is not good enough. The dominant culture is being confronted and challenged to participate in a creative healing process that involves both cultures.

Within Alberta, Government and Native people are on the forefront of this examination process. Although the communication and understanding between the two has not always been crystal clear, at least attempts at cross-cultural understanding and sharing have occurred. Both sides have expressed a willingness to cooperate and the process continues. Child Welfare agreements between the government of Alberta and Indian Bands exemplify this willingness to cooperate. It is now time that an equally cooperative venture occur in the area of children's mental health. This area presents a new challenge to Native people and Government.

We believe that children's mental health is separate and distinct from both adult mental health services and child protection services. While the experience gained from child welfare agreement negotiations is valuable, a reliance upon that process to develop a mental health system for Native children would be a mistake. Rather, it is essential that Native people be encouraged, supported and challenged to create their own children's mental health systems. Government's general role must be one of appropriate and sensitive leadership, coordination, support and offering of resources (financial and otherwise).

In offering the following observations and recommendations we have attempted to view the Alberta Native scene as a creative, powerful and energized pool from which those whose responsibility it becomes to design and implement the service, may draw. To date, this pool has only superficially been accessed and, therefore, our recommendations are tenuous and we are faced with many more questions than answers.

1. THE ALBERTA SCENE

Defining The Arena

At first glance, Native people in Alberta appear to be caught in the same negative traps as the general Native population in Canada. The tendency of the helping professionals has been to react quickly from a crises intervention perspective and therefore, many services have been incoherent, sporadic and directed towards the "mental illness indicators" that are obvious. There has been little attempt until recently to coordinate services to children.

Various Government departments have mandates that include mental health components. The Department of Social Services has, traditionally, been the main provider of service to Native children in need. Although well motivated, these services have often represented a "last ditch effort" to deal with a growing number of Native children who are expressing their pain in various ways. There has been little time or resources left to consider issues such as community based programs, preventive approaches, etc. Recently, there has been some attempt to improve the situtation through developments such as Native liason personnel, Native recruitment officers, and coordination personnel. The services are available through Government but many native children and families remain unserviced and in pain.

Indentifying the Needs

Because of the constant demands upon various service providers, little energy has been left to consider those Native people beyond the scope of present services. The tendency has been to identify need in terms of the recipients already in contact with services. The call has been for more of the same service and that activity would somehow fill the needs of Native children and families. Few attempts have been made to include recipients input in need identification and the asumption has been that "the professionals know best".

Current Strategies

The assumption has been made that present systems could probably address the mental health needs of Native children and families, if only there was increased staff. A further assumption suggests that at least some of the increased staff should be Native people. Thereby, the issue of services to Native children and families would be dealt with.

This strategy is directed to those children and families already experiencing distress or are likely to. There are virtually no current strategies that adequately consider the preventive approach and encourage the development of quality services.

A change in strategy must occur. Involvement of the community and its resources, both in terms of so-called "treatment" and preventive programs, must occur. From our persective, a Native Children's Mental Health Service would assume leadership in moving in that direction.

Resources

We recognize that resources, professional and financial, are in short supply expecially in the area of services to Native people. We also acknowledge that, at first glance, the development of children's mental health service to Native children demands an increase in both resources. We contend, however, that without adequate need identification it is impossible to determine the necessary resources. We also believe that the Native and non-Native community has never been regarded as a resource and, therefore, has not been explored.

In short, we believe that the call in Alberta for massive budgets in order to implement a Native children's mental health service is premature and based upon questionable assumptions.

Mobilizing Resources

In Alberta, the history of service to Native people is clouded by the jurisdictional issues. Child Welfare agreements with Indian Bands have only been possible because the Federal Government has been willing to foot the bill. The Federal Government will

not display the same willingness when it comes to children's mental health. Other provincial jurisdictions (Hospitals and Medical Care, Education, Solicitor General, etc.) only pay secondary attention to mental health services and may, in fact, not recognize or accept their responsibility in the area.

The fact remains, that a large number of non-Treaty Native people are the total responsibility of the Alberta Government. In all likelihood, Treaty Indians are Alberta's responsibility in terms of mental health services. Given this situation, the various Alberta Government Departments and jurisdictions that offer some form of mental health services, do not operate in a cooperative manner. Despite attempts at inter-departmental communication, a concerted and collaborative means of delivering service and sharing resources has not occurred. The state of Alberta's current mental health systems almost certainly ensure that the principles outlined earlier in this paper cannot be applied.

2. STRATEGIC PLANNING RECOMMENDATIONS

Introduction

It is clear to us that many questions remain regarding mental health services to Native children. We have atempted to incorporate our questioning approach into the previous section of this document. Most of the questions will remain until further Native input is achieved. At the same time, we are taking the liberty of making several concrete recommendations as to where to go from here. We make these recommendation from the viewpoint that they will be the springboard from which further discussions will leap.

The Mandate

We have argued elsewhere (Fewster, 1986, p. 64) that a clear legal and operational mandate is necessary for the provision of mental health services for children and their families. This applies to a Native service as well. We assume that mental health services to all Native people is a provincial responsibility and therefore a mandate must be included in provincial legislation. The legal mandate for Native services could be included within and subsumed under the legislation pertaining to children's mental health services generally. A more preferable alternative may be to have a specific and separate legal mandate for Native services unlike the Child Welfare Act.

The operational and legal mandate must result from joint consultation among departments, major service providers and interest groups. This would ideally result from and encourage a cooperative effort.

Alberta Mental Health Services would assume the resulting mandate. The following function would then be performed by this jurisdiction in order to fulfill the mandate.

a. **The establishment of a position entitled the Coordinator of Native Children's Mental Health.** This person would report directly to the Director of Children's Mental Health and would be responsible for the overall development of the mental health service for Native children. This person's salary and expenses would be the only immediate resources needed to begin the service.

b. **The establishment of a team responsible for the development, inplementation and evaluation of a Native children's mental health service.** This team should be comprised of both Native and non-Native personnel with a designated team leader. The team would total no more than six people and the member's sole commitment would be to the team and its processes.

   The team would consult, advise and work with Alberta Mental Health Services and specifically the Coordinator of Native Children's Mental Health.

   Using the regional and corporate resources of Alberta Mental Health Services this team would be responsible for all phases of development from identifying needs through to evaluation systems.

   The emphasis within the team would be upon traditional Native process — consensus decision, Elder input, time lines, differential and changing leadership, etc.

   The team would necessarily function over an extended period of time and therefore must become a coherent group. Members should be chosen for their commitment to the process and their knowledge of Native issues.

   The team would be representative of various Native status groups, communities, and regions. Adequate female representation must be maintained. There must be a heavy reliance on Elder input.

c. **The establishment of cross-jurisdictional mechanisms for communciation, collaboration and coordination.** This is especially important in relation to The Department of Social Services but should not exclude other departments.

Obviously, the child welfare system has significant contact with many Native children and families who require some form of mental health service. In fact, many Native children may not require protective services at all. Rather, they may require other services but the child welfare system is the only alternative available.

In any case, specific mental health issues command a concerted effort at cooperation between The Department of Social Services and The Department of Community and Occupational Health. Examples of such issues are the repatriation of Native children, child welfare intake and assessments.

d. **The establishment of linkages with community based Native and non-Native services.** Many mental health initiatives exist already throughout the province and it is important that Alberta Mental Health Services establish and maintain cooperative, supportive and developmental contact with such resources. Examples of such initiatives are the Peigan Nation proposals, Nechi Institute, Native Counselling Services of Alberta, etc.

e. **The establishment of a carefully planned cross-cultural staff-training process for present and future staff.** Such a training process must be creative and imaginative and be mandatory for ALL staff with a view to improving present service to Native people and ensuring a high quality service in the future. The content and process of this training experience must be holistic and include information assimilation, skill development and attitude development or change.

f. **The establishment of regional positions whose responsibility would be to collect information and coordinate regional endeavors.** We assume that regionally based people would be more in tune with specific regional issues. This is in accordance with our emphasis upon regional differences. It would be the responsibility of these regional people to assess regional initiatives and to determine their compatibility with the work of the team and other province wide initiatives.

Their responsibility would also include co-ordination and leadership in terms of regional initiatives.

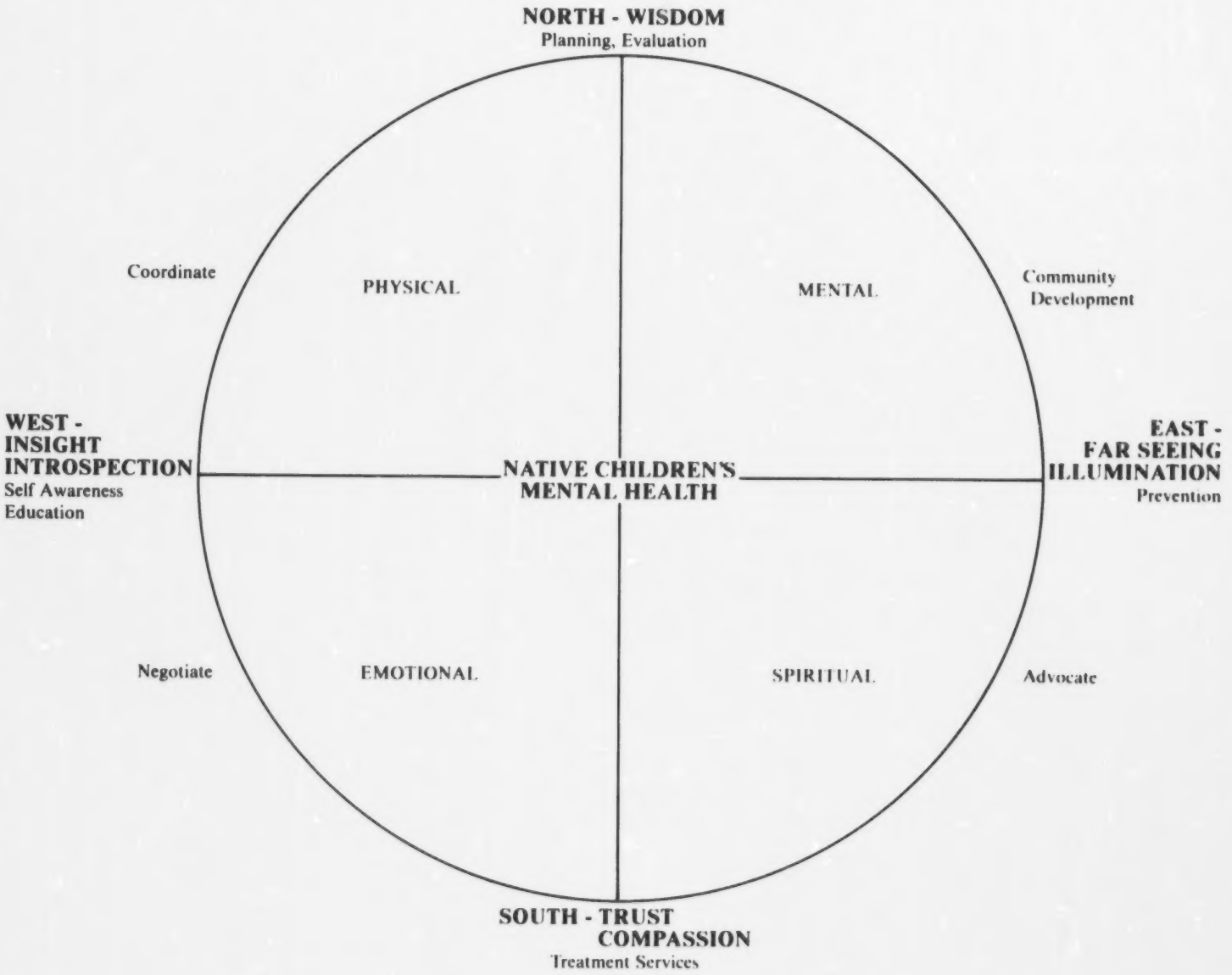
These regional people would work closely with the Coordinator of Native Children's Mental Health and in turn consult with, advise and be advised by the team.

We recognize that, as the Circle is explored, structures and communication mechanisms will shift and change. New structures will form and new communication pathways will be found. The continuing challenge is to ensure that any structure or mechanism is answerable to the People. Old structures will not work. Hierarchical words such as "report to", "accountable to", "subservient to", are irrelevant.

It is absolutely essential to develop and enhance communciation patterns to ensure that the People's voice will be heard and that self-determination will be achieved.

To put it differently, it is our belief that systems are alive and pulsating and are hard to contain within hierarchical structure. In fact, individual, family, community and structural systems often suffer increased pain because of attempts at forcing these systems into hierarchical structures. From our viewpoint, individuals and systems are best viewed from a holistic and circular perspective. We have attempted to represent this view in the following pages of illustrations. It is our attempt to begin drawing from Native tradition and applying it to present systems.

These strategic planning recommendations represent a tentative beginning. Any further recommendations would be premature and reflect the historical attitude of planners that "we know best". Further Native input is necessary prior to any other recommendations.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PHYSICAL
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Community Development
WEST - INSIGHT INTROSPECTION
Self Awareness
Education
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SOUTH - TRUST COMPASSION
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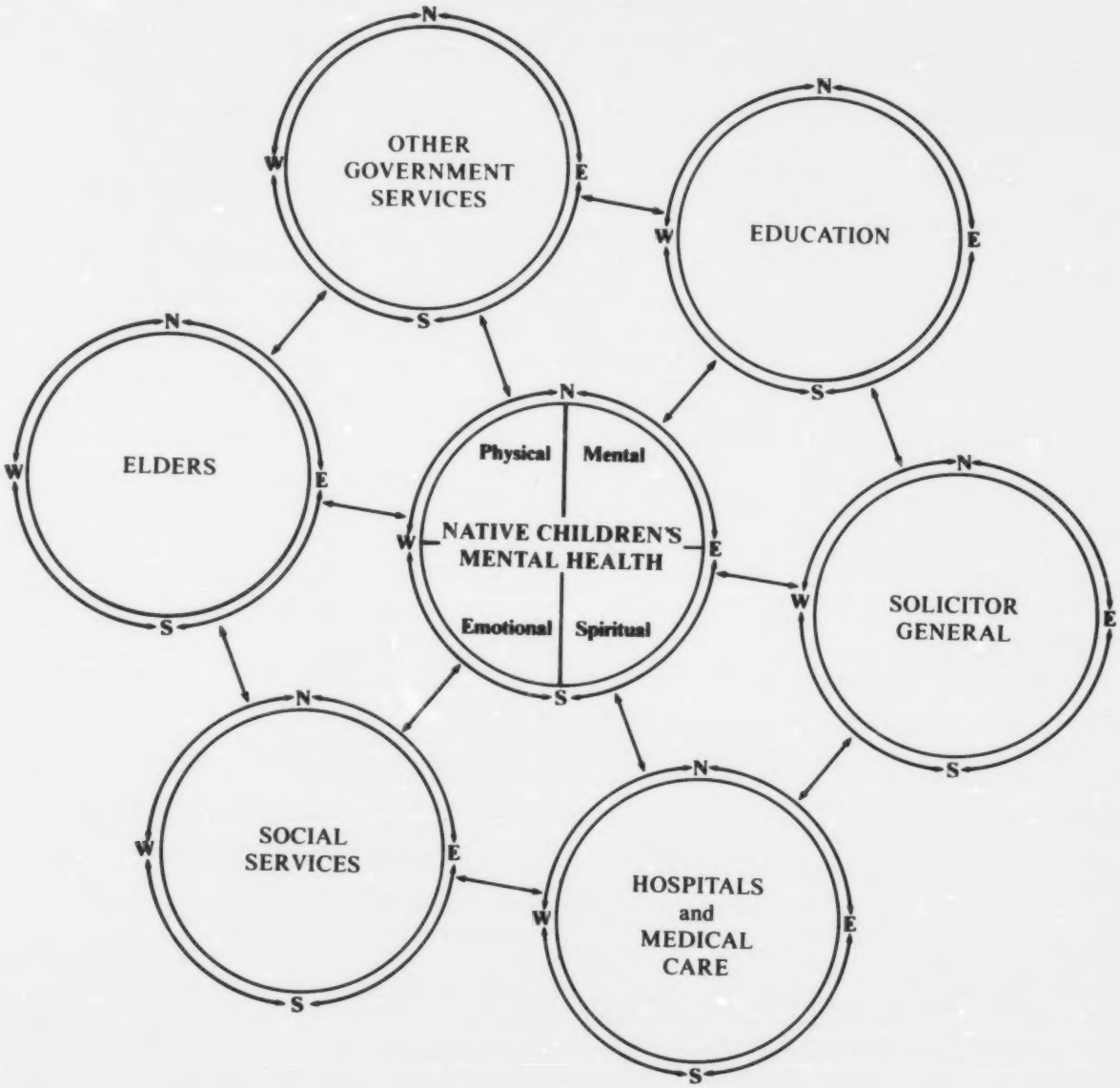
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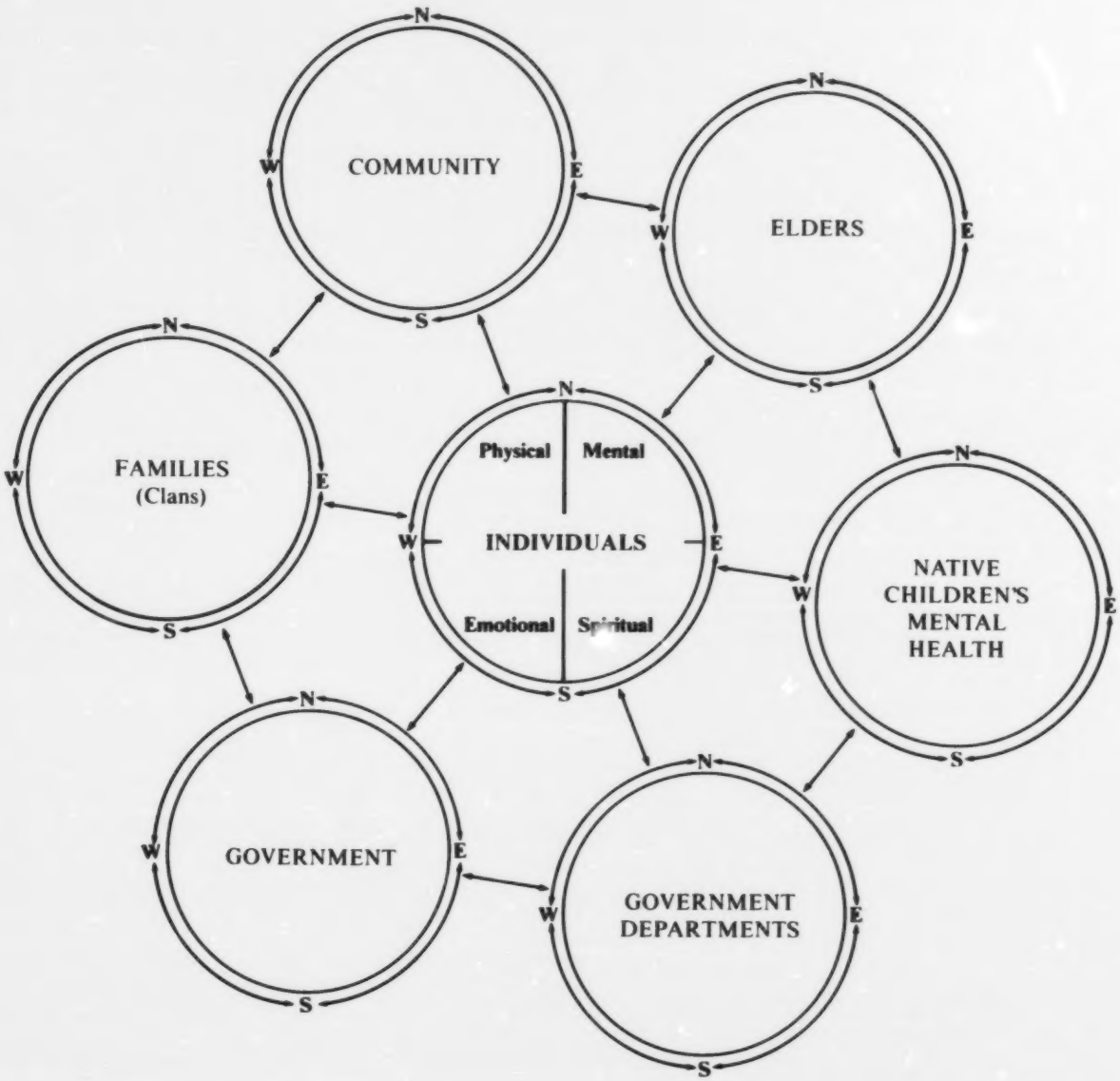
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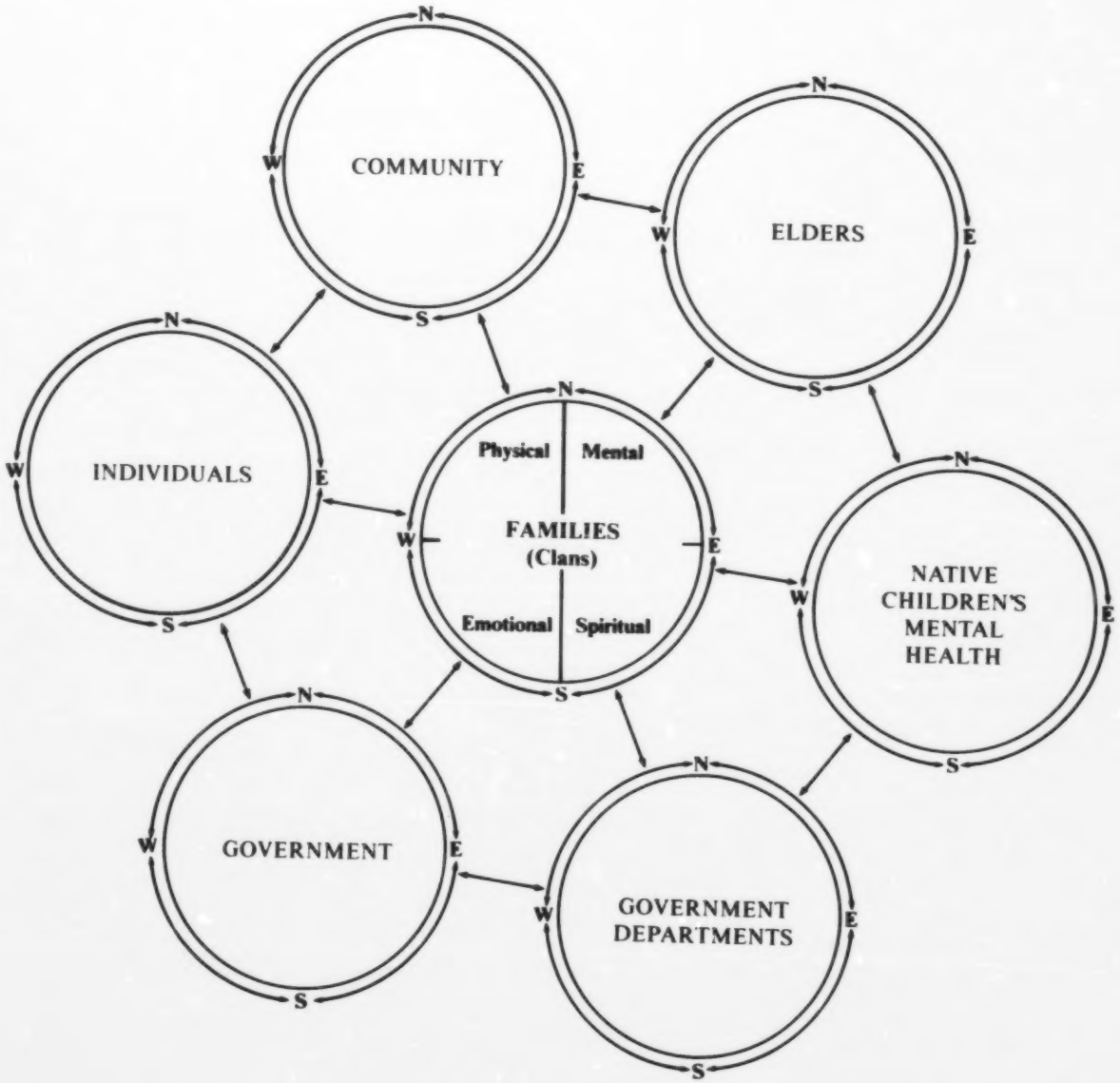
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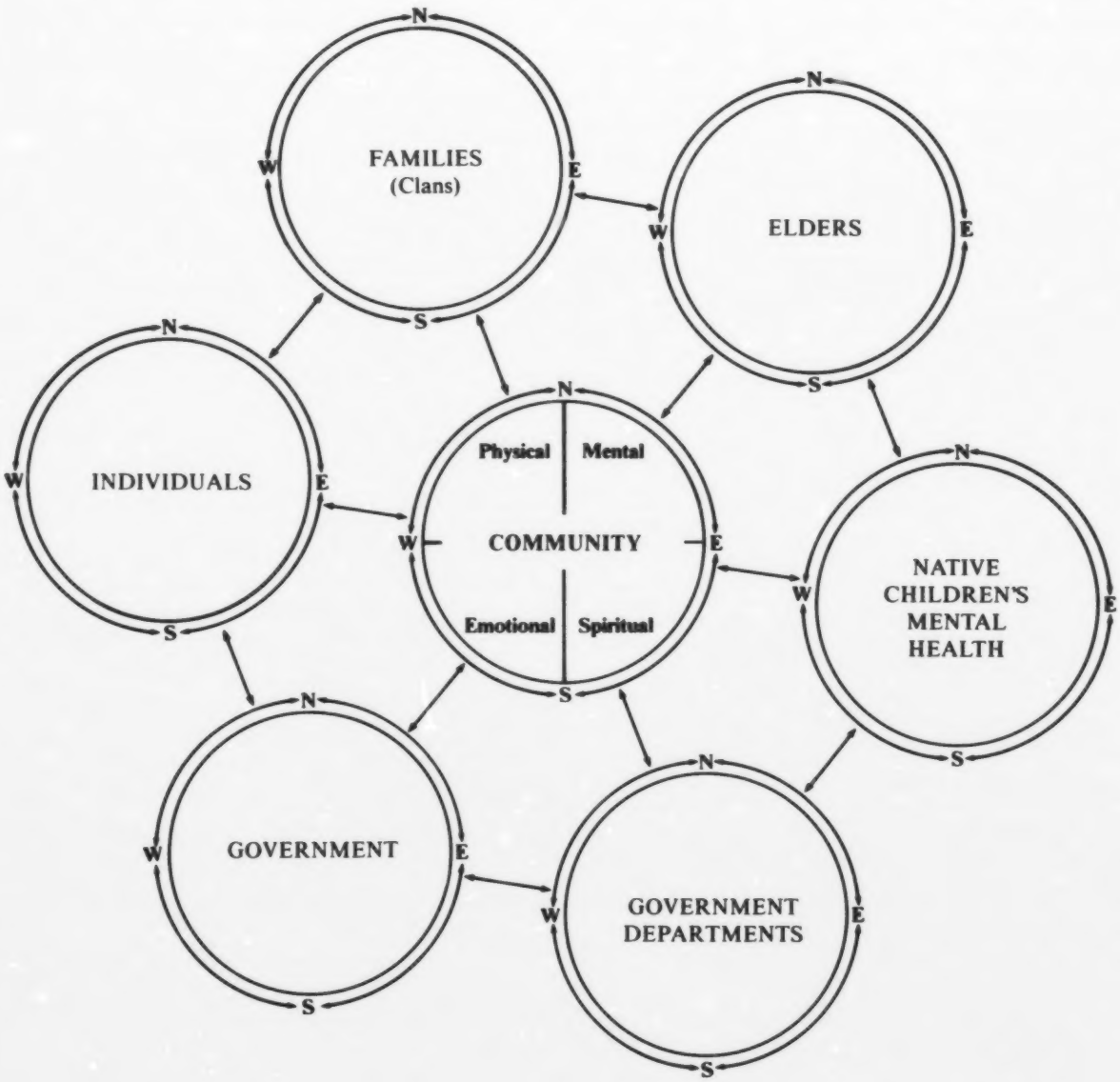
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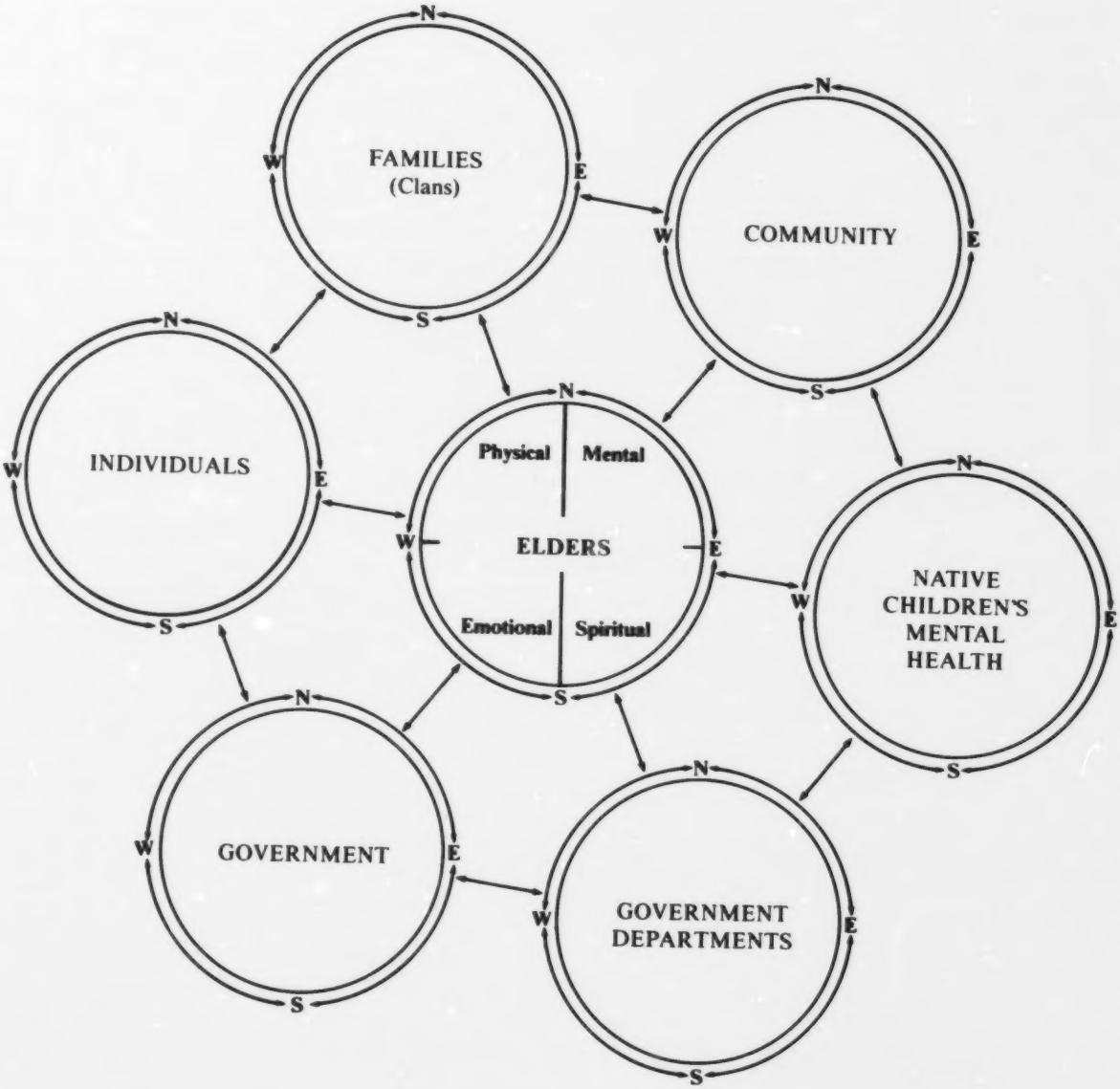
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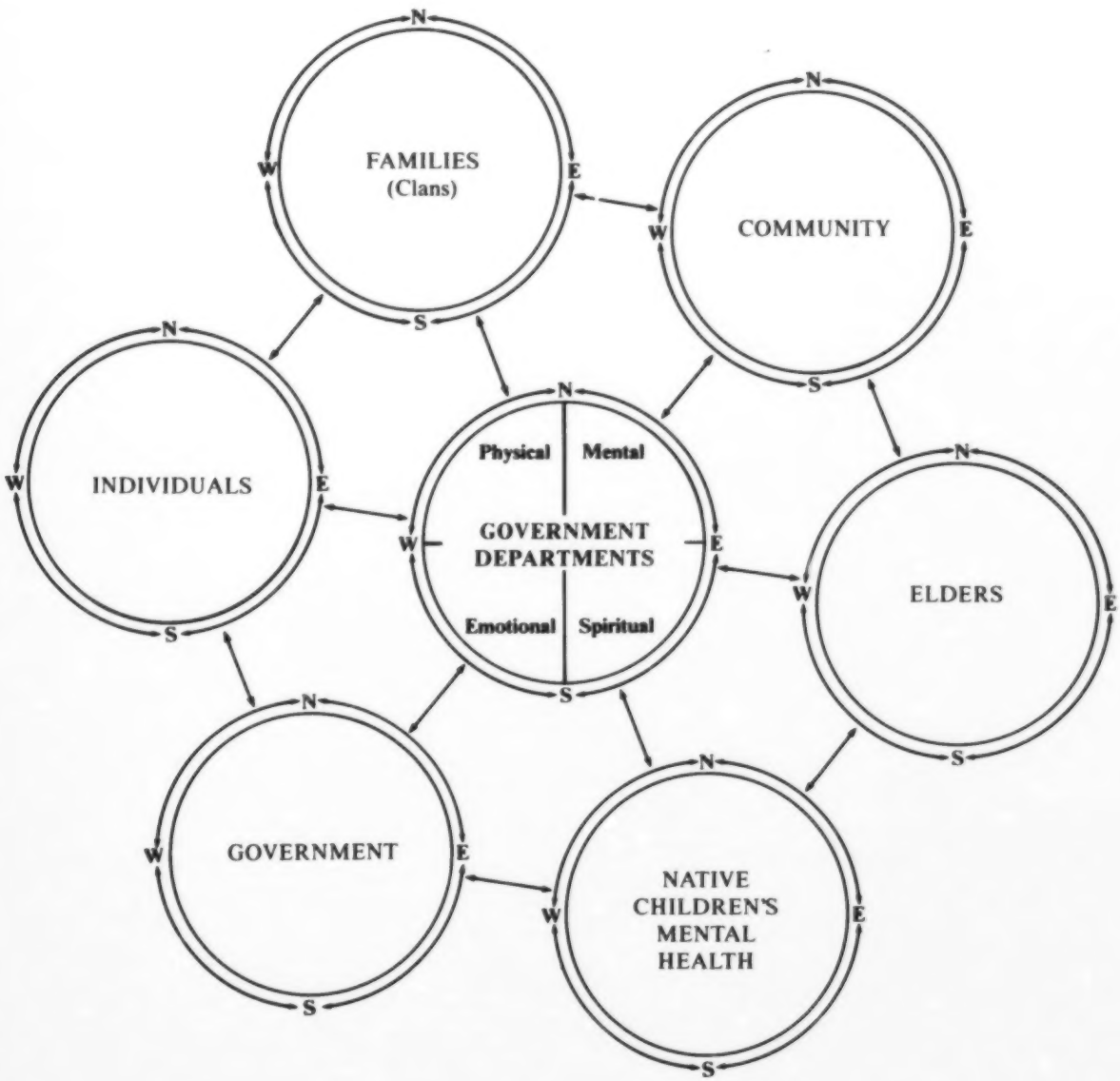
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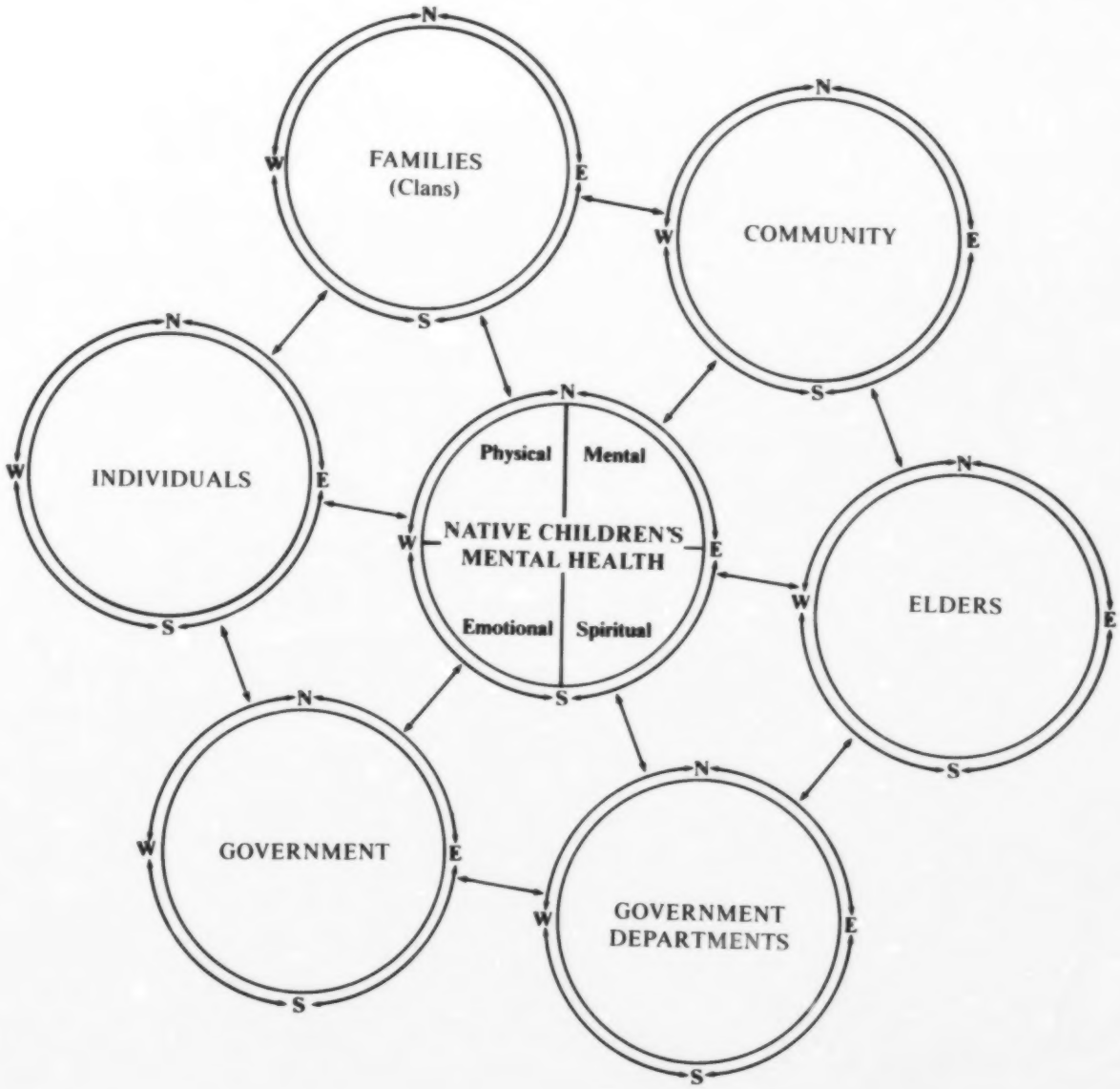
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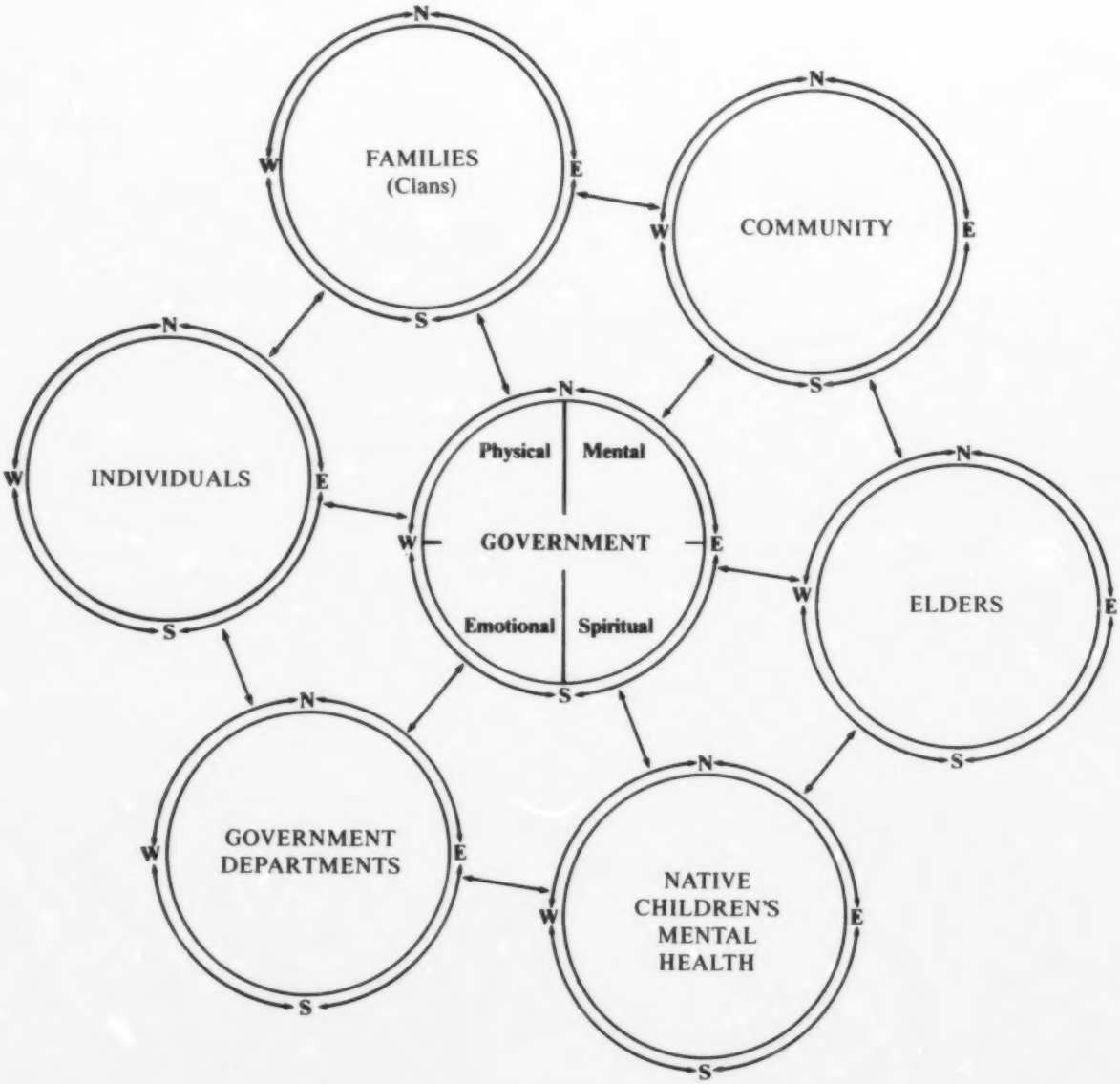
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3. A FINAL WORD

In the Province of Alberta, a Native power and energy is growing. Most of the dominant society establishments remain blissfully unaware of this. They still believe they are the leaders and that, somehow, through their benevolence and insight, the Native condition will improve.

We believe the Native condition is alive, pulsating and in a period of rediscovery. The circle is expanding and the question is whether the "powers that be" and others who have a responsibility to provide service, will join the circle or continue in their attempts to diagnose, disrupt and direct? Will they continue to believe it is they who have the answers to questions already being addressed in Native communities? This is not to say that certain difficulties, confusion and severe growing pains do not exist within Native individuals, families, groups and communities. In fact, there is considerable evidence of pain and many Native children and families are in need of healing.

We believe our purpose was to raise issues, to question the "truths" of present services and systems, to take risks in our attempts to challenge and confront what is and to explore and suggest ways of assisting the expansion of the circle. We are sure that many "experts", Native and non-Native, will take issue with us and attempt to divert attention away from the real mental health issues for Native children and families. We recognize there is no absolute truth. We also recognize that we are all on a frontier that requires exploration, new pathways and a discovery of what that frontier offers. We believe that our concepts and suggestions are in the best interests of Native children and we hope that the response to this document will continue in that vein.

Finally, we hope our document will be regarded as serious and consequential and that the circle will continue to expand with full participation of all those responsible for the lives of Native children. It is now time for full cooperation, understanding and compassion in order to support the healing process already begun by Native people everywhere.

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